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WATCH

THE INDIAN MEDICAL COUNCIL BILL.

SIR SAMUEL HOARE has made the Rupee dependent on the £.

The Government of India wants Medical Education and Medical Relief dependent on the **General Medical** COUNCIL OF ENGLAND.

The Bill proposes to hand over the *Independent* Medical Profession bound hand and foot to the tender mercies of an Official Clique.

BULLETIN

OF THE

SOUTH INDIAN MEDICAL UNION.

SEPTEMBER 1931.

Medical Services and private practice.

We have written under this caption in a previous issue of this Bulletin. We have also referred to this question on various other occasions in its pages, yet we do not apologise for adverting the subject once again The medical public outside the service circle has been agitating against this evil for well nigh two decades. The Union has addressed the Government on several occasions on this grave defect. Nevertheless, we see no sign of any effort on the part of the authorities to remedy the evil. To a recent interpellation in the local council, the Government gave out that the medical men in their service were allowed private practice, as the independent profession was not yet capable of meeting all the demands of the sick public. The answer is vague, but the answers to the supplementary questions indicate that the Government would take the necessary steps to prohibit their men from engaging in private practice if they are satisfied that the independent profession can satisfactorily look after all the sick public outside the hospitals. We question the correctness of the Government's information about the independent profession. But without stopping to argue this point, we welcome the answer, with all its vagueness, as the first authoritative statement which does not maintain that the privilege to practice is unlimited or unconditional.

To a question by a member about nursing homes run by medical officers the Government replied that it had no information. We take it that the reply was given after consulting the head of the medical administration. Since no medical officer could have ventured to run a nursing home without the previous permission of the Surgeon-General, the Government's answers lead us to think that it does not propose to take any action in the matter. We wonder if these replies are manifestations of convulsive states of conscience which is hard put to defend a policy which it believes to be unjust.

It is commonly assumed that this agitation against "Service practice" arises out of a desire of the private practitioners for self-aggrandisement. This is only true to a very small extent—to the extent that no independent profession can grow if it is to be thwarted at any and every step by a set of medical men pampered, protected and generously subsidised by the State. But we are chiefly interested in the vastly more important ethical aspect of this practice. We believe that this privilege undermines the morale of service and that the Government is not given its money's worth by men who must deliberately save their energy and time to look after their own institutions.

Are there any principles which guide the Government regarding this question of practice? Do they approve of their officers running and maintaining nursing homes of their own? And do they encourage their officers to run dispensaries and chemist shops or to ally themselves with chemists and druggists? It would be an act of charity to its servants if the Government would give some definite answers to the above questions without much delay.

Nursing homes.—We have been under the impression that the medical officers of the Government are recruited on an All-India or provincial basis and that they are likely to be transferred in

the interests of the country or service, to any district at any time. This mobility of service is one of the chief arguments for a State-paid medical agency against an honorary one, as well as for the high scale of pay. In these circumstances it is difficult to understand how the Government could have approved of any of its officers maintaining nursing homes in any district. One would like to know if the Government has promised these officers fixity of tenure in one district to the end of their service, for without some such assurance no medical officer is likely to invest his money on a costly nursing establishment. We have known one officer who seriously put forth the argument that a Government servant ran a nursing home in the interest of the Government, that he might do all his private work quickly in one place thus saving the energy and time for Government work which otherwise he would have frittered away in having to run from place to place. But if we are to believe the evidence of these officers before the Lee Commission, none of these officers is likely to have so much private practice. Further, we are not aware of any officer who spends more time or does more work in the hospitals or schools as the result of his owning a nursing home.

Dispensaries and chemist's shops.—If it be the view of the Government that its officers could be allowed to maintain their own nursing homes without any detriment to Government work, we fail to understand why the humbler folks in its employ should be prevented from establishing pharmacies or from allying themselves with dispensing chemists. A druggist's store or a dispensary may be as helpful and lucrative to a general practitioner as a nursing home and operation theatre to a practising surgeon. Yet, we are told, the Surgeon-General has circularised some of the assistant surgeons warning them against such activities. We are unable to understand the principles which may guide such apparently dissimilar decisions. Such contradiction can only follow from confusion between right and wrong, and then, it is not a far step to toneless morale.

We cannot refrain from comparing the present state of discipline in service to what obtained even two decades ago. There have then been officers who proudly refused to take practice as it interfered with their hospital work. We have had officers who refused practice on the score that they were sufficiently well paid by the State and that any outside work should go to enrich the poorly paid assistants or the non-service practitioners in the locality. Those were days where an officer was likely to be transferred from a place if it was found that he has devoting more time to his private work than to that of the Government. We have heard of an instance where a senior Sub-assistant-Surgeon almost at the end of his service, was asked to quit the service because he was unwilling to be transferred from a town where he was running a dispensary in his own premises. On the contrary, we have at present officers and subordinates who are evidently allowed to do what they like without any thought or fear of the higher authorities stepping in at any time.

Honorary Medical Staff.

We invite the attention of the members of the independent medical profession to the text of the Committee's recommendations published elsewhere in this issue. We shall be very glad to receive the considered views of our members on this report which is likely to influence the progress of the profession for the next few years. Pending the receipt of such opinions, we shall just indicate what appears to us as the salient features of

the report. The Committee unanimously agree to the principle of substitution of paid men by honoraries wherever practicable and to an increasing extent. This would remove one of the main defects of the scheme as at present working where all honorary medical officers are considered as supernumerary. This change would enable the Government to more fully avail themselves of the help of the independent profession and would at the same time ensure a sense of responsibility in the minds of the honorary officers themselves. Next, it is satisfactory to note that the honorary officers in the city hospitals would not be liable to transfer except with their consent. The Committee has also made certain recommendations about the question of leave. This subject has been the cause of certain amount of confusion and even hardship till now. By the above three proposals, some of the serious mistakes of the present working rules of the scheme have been sought to be rectified.

The new recommendations strike us as being definite in details, and vague in certain essentials. For instance, the rules about qualification and graduation are *a la mode* and definite. But there is an uneasy vagueness about the allocation of duties.. We admit that it is difficult to avoid a certain amount of vagueness in devising rules to guide a new departure in the scheme of medical relief, especially when it has to be artistically dovetailed into the existing order. But the provision that honorary physicians and surgeons should have a certain number of beds to look after, should be amended to make it plain that these officers should have an *adequate* share of the work available in each institution. We have had recent instances of honorary physicians appointed to be in charge of ten beds in hospitals with over 150 to 250 medical beds. With the new rules, we may find honorary officers posted to look after five beds or even less in similar institutions. Further we would like that definite provision should be made to enable medical officers practising a speciality like ophthalmology or gynaecology to have out-patient work on definite days of the week, in addition to their in-patient work. Some people might consider that the period of one month recommended as leave available for a year as too narrow. Ordinarily few practitioners would care to be absent from their sphere of work for over a month. But if any of them regularly or in exceptional circumstances desire to be away for six weeks or two months, the rules should not make it unnecessarily difficult for them; at least the improvements in leave rules should not curtail the few privileges that the honorary officers may possess at present. In one important respect the committee's recommendations are disappointing. The Union has been rather keen that the junior honorary officers attached to the teaching hospitals should have collateral duties in the associated school or colleges. The committee has made no proposals in this direction. We hope that before the rules are finally approved, the Government would include in them provisions for the above collateral duties.

The committee evidently had three objects in view. The extension of the honorary scheme, the fitting in of that scheme into the fabric of the present medical administration and the ultimate betterment of medical education and facilities for medical relief. Apart from the errors and omissions that we have above outlined the committee is to be congratulated on the report which is practicable and moderate. We find nothing revolutionary in it as was prophesied by the members in service, nor anything reactionary as was feared by the profession outside. It might appear that too much is left to the

discretion of the superintendents of hospitals and the surgeon-general, especially in allocation of duties. But as these duties have to be fixed up in the first instance with the concurrence of the honorary officer before appointment and taking into account the special type of work that he would be willing to undertake in the particular institution, we do not expect any great difficulty on the score.

The success and rapid expansion of the honorary scheme depend on few factors, the willing service of the independent profession, the public realisation of its advantages, the zeal and fairmindedness of the Surgeon-General and the vigilant interest of the Government. Indifference or hindrance of even one of the parties would retard the success, while the intelligent co-operation of all the four would greatly accelerate the growth of the scheme.

Government Committee on Honorary Medical Officers.

TEXT OF REPORT

The Committee met on two occasions on July the 15th and on August the 8th, 1931, and on each occasion the following members were present: (1) Major-General C. A. Sprawson, C. I. E., V. H. S., I. M. S. (President); Members: (2) Lt.-Col. R. G. G. Croly, I.M.S., Supdt., Government General Hospital, Madras; (3) Dr. A. Lakshmanaswami Mudaliar, B.A, M D., (4) Dr. N. Venkataswami Chetti, M.B., C.M., District Medical Officer, Chingleput; (5) Dr. T. Krishna Menon, M.B C.M., M.R.C.S., L.R C.P.; (6) Dr. T. Satakopan, M.D., (7) Dr. U. Rama Rao, L.M.P., and (8) Dr. K. B. Bhujanga Rao, L.M.P., Dr. C. Natesa Mudaliar, L.M.S., M.L.C, was not present on either occasion.

In the interval between the two meetings of the Committee, the Conference of the District Medical Officers was held, and this Conference discussed several points connected with the employment of Honorary Medical Officers and made recommendations thereon. These recommendations were placed before the Committee on Honorary Medical Officers, who therefore had the advantage of knowing the opinions of a large body of senior Medical Officers from the mofussil.

It should be emphasized that though the present Committee on Honorary Medical Officers was representative of several interests yet all its findings on the present occasion have been practically unanimous.

The following recommendations are made by the Committee:—

I. It was agreed that the designation "Honorary Sub-Assistant Surgeon" should be discontinued and that holders of the L.M.P. qualification should be eligible for appointments and for the same nomenclature as medical graduates.

II. No Honorary Medical Officer shall serve in that capacity once he has completed his 55th year.

III. Nomenclature of the Honorary Medical Officers should be considered separately as regards teaching and non-teaching institutions.

NON-TEACHING INSTITUTIONS.

It is decided that there should be three grades of Honorary Medical Officers: (1) Clinical Assistants. (2) Honorary Assistant Surgeons or Honorary Assistant Physicians. (3) Honorary Physician and Honorary Surgeon.

Honorary Medical Officers appointed for a speciality such as Ophthalmology. Ear, Nose and Throat Work, Pathology and Radiology, Venerology, Dermatology, including leprosy work will be appointed to one of the three above grades with further indication as to their speciality. Ordinarily an Honorary Medical Officer will star

from the lowest grade and gradually work up; in exceptional cases and for special reasons the recommending authority may propose deviations from this course.

1. *Clinical Assistants.*—The minimum period that an Honorary Medical Officer shall spend as a Clinical Assistant is two years. From this period the period spent as House Surgeon or House Physician in a Government Hospital may be deducted. The maximum period during which an Honorary Medical Officer can remain as Clinical Assistant is 5 years.

2. *Honorary Assistant Surgeons or Assistant Physicians.*—There should be no time limit for the tenure of office of an Honorary Assistant Surgeon or Honorary Assistant Physician.

3. *Honorary Surgeons and Honorary Physicians.*—Higher academic qualifications although a recommendation shall not be considered essential for these Honorary Surgeon or Physician appointments. But the applicant should satisfy one or more of the following demands: (*a*) that the practitioner has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered and has had actual recent practice in performing the service rendered or services of a similar character, or (*b*) that he has had special academic or postgraduate study which comprises the service rendered: and has had actual recent practice as aforesaid, or (*c*) that he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

TEACHING INSTITUTIONS.

It is decided that there should be three grades of honorary medical officers: (1) Clinical Assistants. (2) Honorary Assistant Surgeons or Honorary Assistant Physicians. (3) Honorary Physcian and Honorary Surgeon.

Honorary Medical Officers appointed for a speciality such as Ophthalmology Ear, Nose and Throat work, Pathology, Radiology, Venerology Dermatology, including leprosy work will be appointed to one of the above three grades with further indication as to their speciality. Ordinarily an Honorary Medical Officer will start from the lowest grade and gradually work up; in exceptional cases and for special reasons the recommending authority may propose deviations from this course.

1. *Clinical Assistants.*—Clinical Assistants in all teaching institutions must hold the degree of M. B. B. S., or its equivalent. The minimum period of appointment should be for two years and the maximum for five years. If an Honorary Medical Officer has served as House Surgeon or House Physician this shall be taken as a recommendation for his appointment and such a period as House Surgeon or House Physician may be allowed to shorten his period as a Clinical Assistant by a maximum of one year.

2. *Honorary Assistant Surgeons and Physicians.*—There should be no time limit for the tenure of office of an Honorary Assistant Surgeon or Honorary Assistant Physician. An Honorary Assistant Surgeon or Physician must have previously performed a minimum period of two years as a Clinical Assistant of which up to one year may be shortened by previous service as a House Surgeon or House Physician.

3. *Honorary Physicians and Surgeons*—One of the following academic qualifications shall be considered essential: M.D, M.S., M.R.C.P., F.R.C.S, or one of the special diplomas signifying skill in the speciality of his appointment.

IV. *House Surgeons and House Physicians.*—The qualifying period as House Surgeon or House Physician must be spent in a hospital approved for that purpose by the Surgeon-General. Though a residential qualification in the hospital is not essential for a House Surgeon or House Physician it is considered preferable. The service of House Surgeon or House Physician is to be whole time at the hospital he serves. He cannot engage in any sort of private practice during his service as a House Surgeon or House Physician. No period less than 6 months as a House Surgeon or House Physician is to be counted towards the deduction of the period to be spent as a Clinical Assistant.

V. For honorary appointments the recommending authority to Government should be as heretofore the Surgeon-General.

VI. The Committee considers that it is impossible at the present stage to specify exactly whether any more or how many paid Government Medical Officers may be replaced by Honorary Medical Officers, but the number should certainly increase and the Surgeon-General will indicate so far as possible when and where this can be done.

DUTIES.

VII. *Allocation of Duties to Honorary Medical Officers.*—In both teaching and non-teaching institutions the Honorary Officers of the third or highest grade Physician or Surgeon, should always have a certain number of hospital beds in their charges. As regards officers of the other two grades the allocation of their duties either in the in-patient or out-patient department or in both will be done by the Superintendent of the Hospital in the Madras City or by the District Medical Officer in the mofussil, leaving the Surgeon-General as a possible source of appeal, if necessary.

VIII. Medical Officers desirous of honorary appointments in special subjects, but who have not had the special training necessary to give them proficiency in that subject, should be trained free of cost at one of the Government Medical Colleges or hospitals attached to a teaching institution for the period considered necessary by the Surgeon-General to give them proficiency, on condition that they execute a bond to the effect that they will serve Government as Honorary Medical Officers in that speciality for a mimimum period of two years at a place to be agreed to beforehand by the applicant and the Surgeon-General.

IX. *Times of Attendance*: (*a*) Honorary Medical Officers who have charge of hospital beds should attend the hospital daily except Sundays. Medical Officers who have only out-patients in their charge may attend daily, but need not attend, after previous arrangement with the Superintendent of the Hospital and the District Medical Officer, more than three days a week.

(*b*) In non-teaching institutions Honorary Medical Officers must make their hospital visits during the recognised hospital working hours.

(*c*) In the case of teaching institutions, the honorary officers shall be present at the respective hospitals on such days and at such hours as may be necessary for the proper instructions of the student—*vide* rule 10 of G. O. No. 1373 P. H., dated 31st May 1929: " In the hospitals which form training grounds for medical students, the honorary officers will be responsible for imparting clinical instruction to students in connection with the beds in their charge in accordance with such plans as may be laid down by the professor in charge of the medical or surgical unit or by the Superintendent of the Hospital."

(*d*) In the case of Clinical Assistants, Honorary Assistant Surgeons and Honorary Physicians, the hours of attendance at the hospital will be laid down by agreement with the honorary officer and the Superintendent of the Hospital after approval by the Surgeon-General.

X. *Reports on officers.*—There should be confidential reports on Honorary Medical Officers submitted annually to the Surgeon-General in the same manner that confidential reports are submitted on Government officers. It will be advisable to devise a special and simpler form for the reports on Honorary Medical Officers.

XI. *Leave.*—Casual Leave: Up to 15 days in a year, as to Government Medical Officers may be granted to Honorary Medical Officers.

Ordinary leave: May be granted up to one month in a year. More than one month cannot be given except in cases of sickness. The one month a year leave can be accumulated up to a maximum of 3 months at one time.

Sick leave: Can be given on an acceptable medical certificate.

Long leave: Honorary Medical Officers should be considered available for long leave on the following terms: An Honorary Medical Officer should be considered to have a lien on his appointment during long leave if he has served at least one year and desires a period of study leave, or, if the leave desired does not include a period of study, then he should have served at least five years before being considered to have a lien on his appointment.

The period of lien may extend to two years' absence if the leave includes a period of study; but only to one year's absence if the leave does not include a period of study. Substitutes for Honorary Medical Officers during the period of their leave will be arranged by the Superintendent of the Hospital: Honorary Medical Officers are expected to aid the Superintendent so far as possible by giving as long notice as possible of their expected absence and by full appreciation of their responsibility towards their patients.

XII. *Termination of Service.*—A noitce of three months as already laid down is necessary on either side. Re-employment: If an Honorary Medical Officer be re employed after discharge he will be accepted into his former rank.

TRANSFER.

XIII. *Transfer of Honorary Medical Officers* from one hospital to another in Madras City will be effected by the Surgeon-General having regard to the needs of the hospital concerned and provided the transfer be agreeable to the honorary officer concerned.

XIV. Salary of paid appointments when filled by Honorary Medical Officers: (1) Recognising the limitation of the terms of reference of this Committee and without recommending any increase of expenditure the Committee express the opinion that when an academic appointment is combined with honorary clinical work, that the Honorary Medical Officer holding these two appointments should receive a remuneration for the academic teaching. (2) If an Honorary Medical Officer be put in charge of a hospital or dispensary during the absence on leave of a Government Medical Officer, the Honorary Medical Officer should be paid an honorarium not for professional work but for the Administration of Government affairs that he carries out during that period.

XV. *Special cases.*—The Committee considers that graduates who have served as House Surgeons and House Physicians and have been selected or may be selected after the competitive examination for Assistant Surgeons in the year 1929 may be permitted to commence service in an honorary

appointment in the grade of Honorary Assistant Surgeon or Physician.

All-India Licentiates' Association (Madras.)

At an urgent meeting of the Madras Branch of the All-India Medical Licentiates' Association held at 323, Thambu Chetti Street, Georgetown, on the 24th Angust, the following among other resolutions were unanimously passed:—

That this Association strongly urges the Surgeon-General and the Government to introduce the much-needed and absolutely essential reform of the introduction of the five years' course in the Medical Schools as early as possible as the medical curriculum extends in no other civilised country for less than five years and as the country is not any more in need of medical men of a shorter training.

SUB-ASSISTANT SURGEONS' CADRE.

That this Association views with great concern a wide-spread rumour that there is a proposal to retrench the cadre of Sub-Assistant Surgeons in the Medical Department, Madras, and if this be true, the Association humbly begs to place before the Surgeon-General and the Government that this step will adversely affect the interests of the Sub-Assistant Surgeons in service and the Licentiates in general as well as those of the public at large, especially the poor and the helpless, even in the remotest hamlets in view of the following facts:—(*a*) That this class of men (Sub-Assistant Surgeons) have done excellent service during the late war under the most trying circumstances some of them have given their lives in the discharge of their duties in the firing lines and others having done their arduous work almost at the same rate of pay all over India and the frontiers—these facts being well-known to the Officers of the Indian Medical Service under whom they served. (*b*) That this class of men form the bulwark and backbone of the medical profession (constituting not less than 4/5 of the registered practitioners of the Presidency) who, when employed by the Government, have discharged their duties creditably even though they are ill-paid and over-worked. (*c*) That the majority of the men of this class only are sent out on jail service and agency tracts and cholera and plague duties, where there had been occasional casualties also in the performance of their duties in such dangerous and unhealthy areas.

That this Association begs to submit that it will involve no impairment of efficiency if most of the Taluk Head-quarters are left in charge of the deserving men of the Sub-Assistant Surgeon class since at present, the utility and efficiency of the surgical centres can well be maintained by them, there being now-a-days available for consultation a large number of private practitioners of wide experience and good qualifications in mofussil parts also.

MEDICAL SCHOOL APPOINTMENTS.

That this Association earnestly begs to request that the appointments in the Medical Schools as Assistant Lecturers and Demonstrators may exclusively be reserved as at present for Sub-Assistant Surgeons, as the present incumbents are mostly men of approved merits and long service in teaching institutions and also are in possession of additional qualifications.

Further the Association begs to point out that those are the only appointments in teaching institutions open to this class of men (unlike the Assistant Surgeons to whom a number of professional appointments till now held by I. M. S. Officers are being thrown open) and the continuance of teaching appointments to Licentiates in the institutions is the only impetus for this class of men to improve their

professional knowledge and also to obtain higher qualifications either in India or abroad.

That this Association respectfully begs to point out the inadequacy of the present scale of teaching allowance for the Assistant Lecturers, *i.e.*, Rs. 30 per mensem for the arduous nature of their duties in addition to their professional work in the hospital and therefore prays that this meagre allowance may not under any circumstances be reduced during retrenchment. In this connection it begs to place before the authorities that it was only some years ago the scale of teaching allowance was reduced from Rs. 50 to Rs. 30, while there was an actual increase of the allowance from Rs. 75 to Rs. 100 to the Lecturers.

That this Association requests the Government that the practice of granting study leave, etc., to deserving Sub-Assistant Surgeons of exceptional merits may be allowed to continue, as the State is benefited financially by sending this class of men most of whom returning with the same, if not better qualifications like the graduate at a proportionately lesser expenditure to the Government.

Promotion to Assistant Surgeons' Grade.

That this Association views with grave anxiety the introduction of the system of appointing graduates in the cadre of Sub-Assistant Surgeons which not only deprives the chances of some more of the Licentiates for getting into service but eventually affects the promotion of Sub-Assistant Surgeons to selection grade appointments.

That this Association begs to place before the Government that it is only a very few of the Sub-Assistant Surgeons who have the facilities (pecuniary or otherwise) to obtain higher and registrable qualification in the United Kingdom of Great Britain and Ireland and other foreign Universities, many of them having invariably obtained very high qualifications in minimum periods of study and none of them having so far returned without obtaining at least one registrable qualification of the General Medical Council and hence prays that such men may immediately be promoted to the Assistant Surgeon's cadre either in temporary or permanent vacancies and that a definite percentage of Assistant-Surgeons' appointments may be reserved for the Sub-Assistant Surgeon class as is done in the case of Civil Assistant Surgeons for promotion to Civil Surgeoncies. In this connection it begs to point out that the promotion of permanent Sub Assistant Surgeons to Assistant Surgeons may be guided by the rules in force prior to their leaving India for such studies and that the interests of the permanent Sub-Assistant Surgeons will in no way be hampered by confirmation of the temporary Assistant Surgeons or by a Government Order or notification that are passed subsequent to their leaving India and that the number of appointments of Sub-Assistant Surgeons of more than 20 years for exceptional merits as Assistant Surgeons may be increased by at least 50 per cent and that such appointments may be made without much delay whenever vacancies arise.

Retrenchment.

That this Association would humbly suggest to the Surgeon-General that if retrenchment be inevitable it will not cause great hardship if men with 30 years service are asked to retire on full pension and allow others to retire who wish to do so on proportionate pension.

That this Association most humbly requests that the right of existing men in service will not in any way be interfered with by the retrenchment proposals and that it also begs to point out any reduction in the starting pay of Sub-Assistant Surgeons for future

entrants, *i.e.*, below Rs 75 per mensem will be incompatible with the maintenance of the social and economic status of a medical man and that the maximum pay of a Sub-Assistant Surgeon Rs. 200 per mensem is below the scale to which members of other non-gazetted services can rise.

That this Association most humbly appeals to the Surgeon General and to the Superintendents of the Medical Schools to support the cause of Sub-Assistant Surgeons as they deem fit, as these are the officers who are in daily touch with the Licentiates and chiefly concerned in the production and improvement of the Licentiates.

That this Association earnestly requests the members of the Senate and Syndicate of the Madras University that the regulations requiring the L. M. Ps. to pass the Intermediate examination of this University before appearing for the M.B.B.S. examination may be modified as it would necessitate an L.M.P. after 4 years' course in the Medical School to join the Arts course once again and hence prays that the University may be pleased to accept any of the examinations recognised by the General Medical Council of the United Kingdom as equivalent to the Intermediate examination.

South Kanara District Medical Association.

A.—Proceedings of the Business meeting held on 19th September 1931 at 3-30 p.m. in the Wenlock Hospital.

PRESENT:

1. Dr. B. Iswaraiya (*President*).
2. „ M. Shiva Rao.
3. „ K. S. Amritha Rao.
4. „ B. G. Acharya.
5. „ C. M. Pai.
6. „ K. G. Rao.
7. „ U. N. Nayak.
8. „ A. G. Bhat.
9. Dr. C. P. Kamath.
10. „ K. R. Kini.
11. „ W. E. Mascarenhas.
12. „ U. P. Mallya.
13. „ A. G. Rao.
14. „ H. V. Adappa.
15. „ M. N. Pai.

The President Dr. B. Iswaraiya occupied the chair.

1. The Annual Report and the audited statement of accounts be adopted proposed from the chair.—*Passed unanimously.*

2. That the following be the office-bearers for the next year:—

(*a*) Dr. M. Shiva Rao be the President.

(*b*) „ K. R. Kini be the Honorary Secretary and Treasurer.

(*c*) „ W. E. Mascarenhas, Member of the Committee.

(*d*) „ H. V. Adappa, „

(*e*) „ C. P. Kamath, „

(*f*) „ K. Giridhara Rao, „

(*g*) „ A. G. Bhat, „

Passed unanimously.

3. That the following bye-law be added to the existing bye-laws as bye-law No. 18:—

" 18. In case a resident member fails to pay his subscription for three consecutive months and a non-resident member for two consecutive half years, a reminder shall be sent in the fourth month to the resident member and at the beginning of the third half year to the non-resident member. Failure to pay up the dues within a fortnight of the receipt of such notice shall cause his membership to cease. Such member may rejoin on paying up arrears due. Any amount outstanding against a member under this bye-law shall be written off the accounts by the Managing Committee at its next meeting, on report by the Honorary Secretary." Proposed by the Secretary and *passed unanimously.*

4. Proposal No. 1 by Dr. C. M. Pai to lie over.

5. Proposal No. 2 by Dr. C. M. Pai as amended by the President do run as follows:

"Resolved that provided funds permit, the following journals be subscribed for the Association:—

(1) The International Digest of Medicine.

(2) The Clinical Journal.

(3) The Post-Graduate Medical Journal".—*Passed unanimously.*

The third resolution by Dr. C. M. Pai is withdrawn.

6. That this meeting places on record the great appreciation of the members of this Association of the valuable work done by its Honorary Secretary Dr. K. R. Kini, M.B., B.S., during past year. Proposed by Dr. C. P. Kamath and seconded by Dr. A. G. Bhat and supported by the President.—*Passed unanimously.*

After thanksgiving the meeting terminated.

B.—ANNUAL REPORT.

On a requisition from the District Medical Officer, South Kanara, dated 2nd June 1930, a meeting of the Medical Practitioners of the Allopathic system, was held in the Wenlock Hospital on 28th June 1930. Lt.-Col. D. C. Rai, I.M.S., was voted to the chair and the South Kanara District Medical Association was duly formed and its office-bearers chosen. The Executive Committee was directed to draw up the necessary bye-laws and place before the General Body meeting on 26th July 1930. Accordingly the bye-laws were drawn up and duly adopted by the General Body on 26th July 1930.

Membership.—Membership is divided into two classes, *viz.*, resident for practitioners within Municipal limits and non-resident for practitioners outside Municipal limits. The Association started with 19 resident and one non-resident member on the day of inauguration. Four resident members did not continue their membership from the very start. Eight resident and 17 non-resident members joined during the year. Two resigned during the year. The membership on 30th June 1931 being 23 resident and 18 non-resident totalling 41 on the rolls.

Finance.—An entrance fee of Re. 1 was collected from all members, monthly subscription of Re. 1 is being collected from resident members and a half-yearly subscription of Rs. 2 from non-resident members. Total collections for the year amount to Rs. 361 and the expenditure Rs. 238-0-4 leaving a balance of Rs. 122-15-8. There are arrears of subscription amounting to Rs. 61. It is hoped that the members will pay up the same early. The audited statement of accounts is given in Appendix II.

Management.—The Association is managed by an Executive Committee of seven members, consisting of, the President, the Honorary Secretary and Treasurer, and five other members. Lt.-Col. D. G. Rai, I.M.S., the first President of the Association, left Mangalore in August 1930 and resigned his office. In October 1930, the Association elected Major N. M. Mehta, I.M.S., as its President, at its monthly meeting on 25th October 1930. There was no other change in the personnel of the Committee during the year. The Committee met three times during the year to transact business.

General Meetings.—The General body met 14 times during the year, the dates and place of meeting being given in Appendix I. Of these, two were ordinary business meetings and one a special general meeting. One was a farewell social meeting. The rest were clinical meetings, where business was transacted at two only. The attendance at the meetings was good. The Committee takes this opportunity of thanking the lecturers who so readily consented to speak at the clinical meetings.

APPENDIX II.

Audited statement of accounts of the South Kanara District Association for the year ending 30th June 1931.

RECEIPTS.

	Rs.	A.	P.	Rs.	A.	P.
By entrance fee due ...	41	0	0			
Less in arrears ...	1	0	0			
				40	0	0
By subscriptions resident due ...	256	0	0			
Less in arrears ...	42	0	0			
				214	0	0
By subscriptions non-resident due ..	66	0	0			
Less in arrears ...	18	0	0			
				48	0	0
By donations for entertainments..				59	0	0
Total ...				361	0	0

EXPENDITURE.

	Rs.	A.	P.	Rs.	A.	P.
To Stamps ...				17	13	0
,, Entertainment ...				53	12	6
,, Printing and Stationery ...				26	10	6
,, Establishment charges ...				60	0	0
,, Journals ...				72	8	4
,, Contingencies ...				7	4	0
,, Closing balance on current a/c at the						
Canara Bank, Ltd. ...	98	14	0			
Cash on hand ...	24	1	8			
				122	15	8
Total ...				361	0	0

Audited and found correct.

KODIYALBAIL P. O.,
SOUTH KANARA,
1st September 1931.

A. F. COELHO,
V. N. NAYAK,
Honorary Auditors.

K. R. KINI,
Honorary Secretary and Treasurer.

Journals.—From January 1931 the Association has been getting the following journals:—

1. The Indian Medical Gazette ... Monthly
2. The Practitioner ... Monthly
3. The Journal of the American Medical Association ... Weekly

The Journals are circulated among the resident members first and then sent to non-resident members. The Journals are sent by rotation to members. Association bears the postage to the first addressee when sending to non-resident members. The members make good use of the Journals.

Habitation.—The Association takes this opportunity of thanking the Government of Madras, for kindly allowing the use of the Wenlock and Lady Goschen Hospital, in their G. O. No. Mis. 2186 P. H., dated 6th September 1930, for its activities. But the handicap of a permanent building for its habitation, is being felt. It is hoped that the Association will be enabled before long, to have a building of its own.

Conclusion.—The Association has finished its first year of existence. The Association thanks one and all, who have helped in its work of successful infant year. Though spectacular work might not have been done, yet, it feels that its existence is justified. It has been instrumental in bringing together medical practitioners and servicemen to understand each other well. The work done is little and much remains to be done. It hopes to achieve all that it possibly can, in the years ahead and thus justify its existence.

APPENDIX I.

28—6—1930. Inaugural meeting for the formation of the Association. Wenlock Hospital.

26—7—1930. Business meeting for adopting the bye-laws of the Association. Wenlock Hospital.

26—7—1930. Special meeting to concert measures to bid farewell to the retiring President. Wenlock Hospital.

23—8—1930. Farewell entertainment to Lt.-Col. D. G. Rai, I.M.S., Retiring President. Government College.

27—9—1930. Lecture by Captain W. E. Mascarenhas, M.D., "Common Fevers in the District." Wenlock Hospital.

20—10—1930. Lecture by Dr. J. Joseph on "Leprosy" with lantern slides Wenlock Hospital.

25—10—1930. Lecture by Major N. M. Mehta, I.M.S., "The present day Medical Practice in some parts of the Presidency. Wenlock Hospital.

20—12—1930. Lecture by Mr. K. R. Kini, M.D., B.S., "Complications and Treatment of Typhoid". Wenlock Hospital.

24—1—1931. Lecture by Dr. M. Shiva Rao, L.R.C.P., M.R.C.S., L.M., "Care of the Perineum during the Labour." Wenlock Hospital.

27—2—1931. Lecture by Dr. M. B. Prabhu, M.B., M.R.C.P., M.M., "Some aspects of child study in Health and Disease". Wenlock Hospital.

21—3—1931. Lecture by Dr. L. P. Fernandez, "Local Anæsthesia". Wenlock Hospital.

27—4—1931. Lecture by Dr. P. S. Karnandkar, M.B., B.S., "Common Corneal diseases". Wenlock Hospital.

23—5—1931. Lecture by Dr. A. Gopala Bhat "Headache as met with in General Practice". Wenlock Hospital.

27—6—1931. Lecture by Major N. M. Mehta, I.M.S. "Contraception". Wenlock Hospital.

ORRESPONDENCE.

Retrenchment in the Medical Department.

Sir,—While retrenchment is in the air, there is a danger that action may be taken in haste and that State policies which have been accepted as sound in all countries may be ignored on the plea of economy.

In the Medical Department, proposals have been made for the abolition of various institutions and for reduction of personnel and equipment. The Medical Department has three functions, prevention of disease, treatment of diseases and education. While all are agreed that the extent of medical treatment and prevention of diseases should not be curtailed appreciably, opinions seem to be divided on the extent to which expense on account of Medical Education could be cut down. Government now finance three types of Medical Education in this Presidency:—(1) The western system of the College standard, (2) The Western system of the school standard and (3) The Indian systems.

There are two Medical Colleges maintained by the Government (one at Madras and another at Vizagapatam). It is admitted that College Education of the western type is expensive but it is a necessity of modern times. It is said that the Vizagapatam Medical College costs Government must more than they think is justified by the results obtained, but we have to remember that it is not easy to start a College, especially a Medical College and before closing down an institution which has cost so much in thought and money, every possible means of effecting economy should be first given a trial.

What the province now needs is education of the College standard. We have too much already of the lower type and are suffering the consequences of our past short-sighted policy of multiplying Medical Schools and it will be nothing short of calamity to let an established College be closed down on the score of temporary financial stringency, while maintaining a school (the Royapuram Medical School) which already asks for a five years' course as well as buildings, equipment and staff which in effect elevate it to the status of a College.

Western Medical Education of the School type is out of date. It was the creation of a time when our standards were low, when it was thought that the aim of Medical Education was only to provide subordinates for the Government Medical Department and that the public especially in the rural areas would be satisfied with a cheap Indian Doctor. The public are not satisfied with low standards nor is the cheap doctor content with his lot. The Government should now make up its mind about Medical Schools in general. Their total abolition is inevitable (including the School at Royapuram) but this may have to be carried out in stages so as not to throw out those who have already joined these schools.

If Medical Education of the School type is not wanted by the Province, then there is no use advocating it in the case of women either. But if they were to close only the Lady Willingdon Medical School, it would look as if Government did the easier thing and dared not suggest the more rational course. All over the country one hears the cry for extending female education. They are asking for more schools and better schools. Infantile mortality is high and cannot be reduced unless more women doctors are available. Alongside this cry, the suggestion to close the Lady Willing-

don Medical School for Women looks incongruous.

It is said that women could be admitted alongside the men at the Royapuram Medical School. I wonder if the same would be suggested as an excuse for closing the Queen Mary's Arts College for Women. If Government accept the policy that Medical Schools should go and that College education should be fostered and that co-education is undesirable, the natural conclusion is that the Lady Willingdon Medical School should not only be maintained but raised to a College, thus creating the only Medical College in Southern India for Women that the Royapuram Medical School should go and the students therein transferred gradually to the Tanjore Medical School which also should be closed in time. In any case, no one acquainted with the finances of this province would suggest that we could afford to maintain two men's Medical Colleges (Madras Medical College and a remodelled one at Royapuram) in the city and a third one at Vizagapatam The Vizagapatam Medical College has been brought into existence after great labour and expenditure and must not be allowed to die so early in its career. If Madras city wants another institution with a five years' course, it should be a central college for the women medical students who are now scattered in three institutions, *viz.*, in the Madras Medical College, the Lady Willingdon Medical School and the Vellore Medical School for Women.

The Government have too many irons in the fire in the matter of Medical Education. They are already committed to a policy of imparting Medical Education of the western type and are spending large sums on buildings and equipment (the General Hospital Remodelling Scheme). While this is going on they are maintaining at Kilpauk an institution where a mixture of Western and Eastern medical sciences is taught. While no kind of instruction is given in the principles of Ayurvedic medicine to the students of the existing medical colleges and schools (western type). Government are imparting instruction in the western medical science to the students of an avowedly indigenous institution like the one at Kilpauk. Here drugs, instruments and other equipment which belongs to western medical science are in daily use. The maintenance of this school in its present state is neither economical nor wise. For by unnecessarily duplicating expenditure on western equipment and drugs which are already available in the larger Government hospital like the General Hospital, etc., this institution is a source of avoidable waste of public funds at a time when Government could ill-afford it. It also suffers from the drawbacks pertaining to low standards (of western medical education) already referred to in the case of Medical schools. While all are agreed about the desirability of merging East with the West we want the best of each and not as in the case of western medicine at the Indian school, something which the students and the public might fancy to be the real thing but which is in reality only an apology for the real thing. In this institution a great deal of public money is spent in the name of Ayurveda but in reality western medical science is responsible for most of its expenditure.

The School of Indian Medicine has already existed for some years and it will repay the Government to order an enquiry into its working by experts in both eastern and western medicine.

MEDICO.

Importation of Drugs.

Sir,—Will you kindly allow me, as the Secretary of the local Chemists and Druggists' Association, to rectify some of the misapprehensions that might be caused by the speech delivered by my

friend Mr. D. R. Mawnay at Vellore before a gathering of medical men ?

The allegations against a few Marwaris doing successful business in the profession are absolutely unwarranted. There need be no qualification for being the proprietor of a shop except a sound financial standing and the ordinary intelligence and common sense to conduct the business satisfactorily. Indeed, Mr. Mawnay himself averse: "It does not matter who handles the trade so long as there is honesty and uprightness in business."

In fact I am yet to find the proprietor of a wholesale chemists' firm in Madras possessing the necessary qualifications for being called a chemist and at the same time there is not a single shop without the necessary number of qualified assistants to run the show and bear the responsibility.

As regards the importation of impure drugs, all are equally guilty either consciously or unconsciously and so the entire blame cannot reasonably be laid at the doors of a particular community simply because they cannot or do not care to answer such charges.

Again, the impurity of drugs is not a monopoly of imported stuff only. Patriotism apart, we have to confess that there are scores of mushroom companies in India, some with good organisations, who attempt to imitate all foreign proprietary medicines of note. Nobody will deny the need for control but it is meaningless to expect that such control will in any way solve the problem of "unhealthy competition." There is this trouble all the world over, and nothing but an understanding among the merchants themselves can offer any solution.

V. SRINIVASAN.

21st September, 1931.

X-Ray Examination of the Heart and the great Vessels.*

Dr. P. Rama Rau, Madras,

Unique X-Ray Institute.

Of the graphic methods in the examination of the heart and the circulatory system you are all more conversant with the Sphygmograph and the Electrocardiograph. My subject of this evening elaborates the Orthodiagraphic method combined with study of skiagrams, which will give us so much more clinical aid in diagnosing conditions of the circulatory system. Shall I say valuable accurate information to the clinician regarding diagnosis, prognosis and treatment ?

With the fluoroscope, tracings are made of the outlines of the heart and the great vessels on oil paper fixed over the screen, which depict the actual outline of the organ—the resulting 'orthodiagram' combined with a skiagram taken with an anodal distance of 6 ft. will enable a systematic examination. Great importance is attached to the 6 ft. film as the divergent radiations passing through will cause considerable distortion if the rays emanate from a nearer anode. The patient stands in the postero-anterior position behind the screen and after making a note of the habits and individual normal variations in the size and shape of the heart shadow, the left border of the heart, and the position of the diaphragm on either side are marked with the breath held after forced inspiration and again in forced expiration. An accurate tracing of the left border is then made marking particularly the junction of the left auricular appendage with the left ventricle. You find an orderly pulsation corresponding to the

* Read before South Indian Medical Union, Madras.

left ventricle above which is an area showing a 'rocking bar' movement. The junction of these two readily recognisable segments is marked by a point known as "Node of no motion"—This also moves up down and the lowest limit of its travel is marked and that denotes the left auriculo-ventricular junction. This tracing is superimposed on the six-foot film. Finally a measurement is made of the greatest internal transverse diameter of the thorax. Then the patient is rotated into the right anterior and left anterior oblique positions, tracings of the vessels and heart made and any posterior mediastinal opacities and abnormalities noted. Then the six-foot film anode distance exposures are made, breath held in inspiration and tube centred over the spine of the 6th Dorsal Vertibra.

In the posterior anterior view, the curve forming the right side of the heart shadow is entirely the right auricle, above this is the less marked convexity of the right border of the ascending Aorta. On the left side you find 3 convexities—the lowest and largest is the left border of the left ventricle—above this and defined by the 'node of no action' the left auricular appendage—and above this the third, produced by the Conus Pulmonalis and the Pulmonary artery —above that left border of aortic arch.

In the first oblique position (right anterior) the right border is formed from above downwards by the posterior aspects of the aortic arch and descending aorta, the left auricle and right auricle. The junction of these three not being quite demonstrable it is usual to allocate a third of the right border to each. Some are of opinion that the upper third is formed by the superior vena cava and not the descending aorta. The left border is formed from above downwards by the aortic arch and ascending aorta, covers pulmonary artery and the left ventricle. These three convexities are usually well differentiated.

In the 2nd oblique position (left anterior) the complete outline of the aortic arch is seen above, below this right border is formed by the right auricle (about 4/5ths) and the lower part by the right ventricle. The left border is formed above by the left auricle and below by the left ventricle in the proportion of 1 to 3.

Cardiac diameters.—This is carried out on a true postero-anterior film, the mid-line being drawn through the centre of the dorsal spines. *The transverse diameter* is the sum of two lines drawn perpendicularly to the left and right from the mid-line to points farthest on the margins of the shadow. *The long diameter* is drawn from the most prominent point of the apex to the right border at the junction of right auricle and aorta. *The diameter of the base* is the sum of 2 lines drawn perpendicularly to the long diameter from the most distant point of the out line on the right and from the junction of the auricle and ventricle on the left. They say these 2 lines roughly divide the long diameter into an auricular portion lying above and to the right and a ventricular portion below and to the left. The obliquity of the cardiac axis is represented by the angle formed by the intersection of the transverse and long diameters. Finally the diameter of the aortic arch is drawn transversely across the greatest width of the arch opposite to the anterior ends of the 2nd ribs.

Heart shadows vary according to the types of Habitus. The following measurements from Mills will not be out of place?

Types.	Transverse diameter.	Long diameter.	Diameter of base.	Obliquity of cardiac axis.	Aortic arch.
Asthenic ...	8·8 cm.	11·4 cm.	9·9 cm.	48°	3·9 cm.
Hyposthenic ...	11·1 cm.	13·1 cm.	10·6 cm.	43°	4·8 cm.
Sthenic ...	12·4 cm.	14·1 cm.	10 6 cm.	37°	5·1 cm.
Hypersthenic ...	13·8 cm.	14·7 cm.	10·7 cm.	33°	5·7 cm.

Asthenic heart is long and narrow and	Cardio Vascular angle.	180° pointed apex.
Hyposthenic	circular.	165° slightly rounded.
Sthenic	triangular.	150° moderately rounded.
Hypersthenic	oval.	135° a greater rotundity.

For determining cardiac enlargement, generally the cardiothoracic ratio is accepted as accurate. This is obtained by dividing the transverse diameter of the heart by the greatest internal transverse diameter of the thorax measured inspiration. A ratio of more than 50 per cent. indicates enlargement. In early left ventricular enlargement no variation will be found. Morrison and White have devised a means of estimating this increase which method offers an easy and accurate means of recognition where no clinical evidence of abnormality is found. The patient stands upright behind the screen, which is 60 cm. from the anode and the tube is adjusted so that the central Ray passes through the heart apex. A mark is made on the screen over the apex and the tube is moved 10 cm. to the left. The shadow of the apex will now be seen to lie to the right of its original position and it is again marked on the screen. The displacement of the apex shadow is known as the cardio radiographic index and is measured in millimeters. The displacement is the result of the obliquity of radiation which forms the marginal shadow after movement of the tube and hence furnishes an indication of backward convexity of the left ventricle. The cardio-radiographic index of the normal heart varies from 7 to 14 mm. and an average of 10 mm. The highest abnormal index reported by the above authors is 42 mm. in a case of chronic nephirtis.

It might interest you to know the different functional tests possible with the aid of X-Rays. During and immediately after work the heart increases in its diastolic size but is normal in its systolic size. The increase in diastole being due to muscular and respiratory activity and normal systolic size showing the capacity to completely empty. Only when there is residue in the heart chambers after systole, *i.e.*, when the systolic size is greater than normal that presence of insufficiency is evident.

Then you have the myocardial retraction and dilatation reflexes. Minerby says that when the precordial region is tapped or irritated by spray-

ing ether, or when the 7th cervical vertebra is tapped, retraction of the shadow takes place showing the heart outline 1—2 or more centimeters inside the previous marking. In large dilatations and myocardial degeneration the heart does not respond to these stimuli and indication is insufficiency. However the presence of these reflexes in heart cases is a good prognosis.

Then again (Breccia) peripheral irritation caused by percussing the spinous processes of the 9th, 10th, 11th and 12th dorsal vertebra or by briskly tapping upper abdomen you see enlargement of heart shadow returning to normal in a few minutes, indicating myocardial insufficiency. In other words, it is a sign of weakness to respond to the extra demands made by the mechanical stimulation of the abdominal aorta and indicates a heart below par. In 100 cases of mitral defect Breccia found this reaction present in weak and decompensated cases. Absence of this is a good prognosis.

Now coming to diseased abnormal conditions—pericarditis with effusion is a difficult problem—appearances closely simulating acute dilatation of heart, cardiac opacity is enlarged, pulsation greatly diminished, shadow more triangular. In effusion however the shape of the opacity changes when the patient is placed in the supine position; occasionally a heart shadow inside that of the effusion might be observed, changes in the cardiophrenic angle are observed—some say more acute and others obtuse. Pulsation of the lower margin of the heart normally transmitted to air bubble in the cardiaca of the stomach is less pronounced on account of the fluid intervening. The air bubble can be rendered more conspicuous by administration of effervescent powder. When adhesions are present as in cases of chronic pericarditis a shadow at the left side where the heart and diaphragm are soldered together is an important finding. The heart shadow might still be larger during convalescence in pericarditis with effusion but should be differentiated from the adhesive type by percussion which reveals the true heart outline. In cases of adhesion the heart shadow exceeds the area of dullness. You should always bear in mind the emphysematous lung. Pneumo-pericardium shows presence of air or gas in the distended sac.

In valvular diseases you get characteristic changes in shape and size and X-ray appearances give exceedingly valuable information. In mitral regurgitation in early compensated cases you get smooth circular enlargement of the left side, later often getting oval, the heart throwing a rather ovoid shadow—longest axis being placed diagonally. In mitral stenosis orthodiagrams in early cases show relatively small oval and vertical axis. The enlarged auricle may be evident. In pure stenosis the left ventricular curve shows little if any increased prominence and the cardiothoracic ratio remains practically normal—this being the only valvular lesion in which the ratio is not appreciably raised. In cases of combined mitral stenosis and regurgitation the left ventricle undergoes some enlargement at a fairly early stage, the back pressure causing enlargement of right ventricle and right auricle with marked prominence of right auricular convexity. The diameter of the base and the transverse diameter are markedly increased and so also the long diameter. The diameter of base may even equal the long diameter. This condition occurs in no other cardiac lesion. The 'round heart' characterising mitral stenosis and regurgitation, and the 'boxing glove' heart typifying pure mitral stenosis

which latter condition causes enlargement of all chambers except the left ventricle. Hilar and perihilar shadows are increased in size and density due to dilatation of pulmonary vessels and hazy appearances of the lung shadow due to stasis in the pulmonary circulation are all evident.

In aortic stenosis the ventricles are enlarged especially the left, the long and transverse diameters increasing considerably. The lower portion of the heart shadow forming a horizontal oval above which shadows of pulmonary artery and aorta are quite visible. It is indeed difficult to differentiate this from the cardiac enlargement of chronic renal disease and myocarditis.

Aortic regurgitation is usually associated with enlargement of aorta from proceeding aortitis. The outline becomes more constant than in mitral disease. Region about the apex is enlarged and obtuse apex itself nearre the axillary line—the body of the enlarged left ventricle becomes eggshaped and the whole heart resembles a 'sitting duck', 'the duck heart'. The long and transverse diameters show a marked increase while there is only very slight increase in the diameter of the base. The fluoroscopic examination shows the 'Aortic fling, *i.e.*, under excursion of aorta during the beats and sharp contraction of the left ventricle with distinct lifting of the apex region this becomes more prominent when compensation fails.

In combined mitral and aortic disease all chambers are enlarged, all diameters are increased and the cardio-thoracic ratio becomes very high.

The great vessels.—Increase in the transverse diameter of the aorta may be produced by specific aortitis resulting in fusiform on saccular aneurysm, cardio-renal disease or artereo-sclerosis. In arterio sclerosis the increased width of the shadow is due to a swaying of the descending aorta to the left and can be confirmed by rotating the patient into the first oblique position. The pulsation is diminished and the vascular opacity tends to increase and the knob or projection to the left normally seen at the seemmit of the normal aortic arch in a postero-anterior film is unusually prominent. We could of course rely considerably on the alert ophthalmologist who could confirm our diagnosis by an examination of the ocular fundus. Specific syphilitic aortitis in early stages presents no radiographic abnormality. As it advances, the increase in the transverse diameter is difficult to distinguish from arterio-sclerosis or cardio-renal disease except that in arterio-sclerosis the pulsations tend to be diminished. The smooth clearly defined margins of an aneurysm generally show regular expansile pulsation. The absence of expansile pulsation is of value in distinguishing this from enlarged glands and other upper mediastinal opacities.

Going to College for Your Health.

By Earl F. Morris.

Not so long ago if a young man said he was going to college for his health he was merely trying to be funny. All the health he received from his college courses he could "put in his eye," to quote another phrase of the period.

True, the college student of two or three decades ago had his physiology text, a work prepared by an anatomist and physiologist. The student memorized the names of all the bones

of the body, traced the blood in its circuit through the body and performed many other feats of mental gymnastics. But what did this have to do with his health? About as much as did the mechanistic exercises of the period, in which certain unified movements were performed at absolute and instantaneous obedience to command.

Let us consider a modern college health programme that has as its aim graduation of students whose health has been protected while in college, who have a reasonable amount of health knowledge, and who have been taught to apply their knowledge in the form of health practice.

Such a college health programme will have three distinct phases: (*a*) health service to students while in college, (*b*) health instruction, and (*c*) health practice. There is, and should be, a certain amount of overlapping.

The college health service offers many opportunities for health instruction of an individual nature. A great amount of the health instruction should be motivated by things arising in the health service.

One part of the college health service should be a thorough physical examination of every student at least once each school year. If possible, there should also be a midyear check-up of progress made in the correction of physical defects.

Many colleges to-day make it a practice to examine only new students entering school. Others require all students to undergo a physical examination at the beginning of each school year. Quite often these examinations are done by outside physicians who are in practice and whose major interest is in their practice. The students have little opportunity actually to become acquainted with the doctors, who usually run the examinations through in record time and are gone until the next year. The physical findings are often recorded in an unintelligible fashion and no attempt is made to summarize them in the form of a definite estimate of the physical status of each student, so that he may know just where he stands as compared with his fellow students or as compared with himself at the time of the last examination. Little opportunity is given for consultation or for explanation of the recommendations made. The student is expected to embrace without question the recommendations of some one who is a perfect stranger to him.

Thought He Was Physical Wreck.

A student who recently underwent such an examination said, "The doctors told me that my tonsils were a fright and my nose was worse; also that my posture was bad. I got the impression that I was a physical wreck. They told me to have my tonsils out, although they have never bothered me and I have not had a cold for a year. No other recommendations as to how I might improve were made and I was given no aid in pulling myself out of the rut. I wondered if the doctor who told me to have my tonsils removed was in that business himself."

The reaction of this student is typical. The physical examination failed of its purpose because it omitted the educational side. This boy would have liked to know why certain recommendations were made. To expect one who has never had tonsil symptoms of which he is aware and who feels fine to spend a neat sum of money and submit to an operation simply because some stranger advises it, is expecting too much. He must

be told why, perhaps several times, by some one in whom he has learned to place confidence. This boy would have appreciated knowing how he stood physically as compared with his fellows. As a result of his examination he developed an inferiority complex. Actually, when good and bad points were summed up, he was physically above the average. Another mistake made in his case was the failure to follow up and offer real help.

A physical examination, if it is to be of much value, must be made carefully and recommendations presented in such a way that confidence is inspired. The examiner should be some one with whom the students come in frequent contact. As a physical examination proceeds, definite values should be placed on degrees of physical perfection or imperfection, so that at the end of the examination the whole may be summed up in the form of a definite score. In this way the student is placed in competition with himself and with his fellow students from semester to semester or from year to year. A definite measuring stick in the form of a score is as necessary in a college health programme as is a system of grading in other lines of endeavour.

Real Guidance in Private Consultations

More leisurely private consultations following the physical examination offer limited opportunities for real health guidance. We are told that Charles McMurry, when asked what he would do if he had his life to live over, said: "I would certainly teach, but would want to reserve two-thirds of my time for personal conferences with my pupils". In every college health programme there should be definite hours each day during which students can discuss health problems with those qualified to give advice. It is in these leisurely conferences that many problems of physical, emotional and social health are revealed—problems that are often not discovered in the course of the routine physical examinations.

How Much Medical Treatment?

Just how much actual treatment to include in a college health service is a problem. On the whole, it does not seem wise to attempt the treatment of conditions that require prolonged care. However, the health programme is strengthened if some treatment is offered. This treatment should be mainly in the nature of first aid and preventive therapy. Students will often allow seemingly minor ailments to go without proper attention because they do not see the importance of spending a few dollars early in order to prevent greater expense and physical discomfort later. Just here is a place where the college health service, by offering convenient and inexpensive early treatment, has an opportunity to demonstrate that an ounce of prevention really is worth a pound of cure. The most outstanding results are obtained in those epidemic diseases which can be controlled by vaccination.

Another point in favour of a limited amount of treatment is the added force given to classroom instructions. Students have a greater respect for theoretical health instruction when they know it comes from those who are capable of putting the theory into actual practice.

Included in the health service to students should be inter-departmental co-operative projects. The health department can work to good advantage with the department of home economics in assisting students who have problems in nutrition. With

the health department furnishing physical findings having a bearing on weight and with the dietitian offering guidance in diet, we have an ideal combination for solving problems in nutrition.

In a similar manner the college physician furnishes the instructor in physical education with a complete report of conditions that are best corrected by properly guided physical activities. Speech defects are best attacked by the co-operative efforts of the college physician, the English or speech teacher, and the psychologist. The departments of health and biology can work together to a distinct advantage in solving problems in health of questionable bacteriologic origin. Departments of dramatics and music often find that some of their most perplexing problems have physical causes and are best solved by co-operation with the health department.

Health Instruction

Health instruction may be informal and formal. Health, more than most other subjects, lends itself to the informal type of instruction.

The opportunities for informal health instruction on the average college campus are almost without limit. The very presence on the campus of a health department with its equipment and laboratory serving as a clearing house for problems in health is a silent declaration on the part of the college that the proper setting for a highly trained mind is a well cared for body. The clinical scales found in every health department waiting room and the weight charts hanging near by proclaim the fact that these pieces of equipment are used in the solution of important problems. A clean, well kept and well equipped college health office is in itself a protest against the unhygienic offices that we sometimes encounter, and an endorsement of cleanliness and thoroughness of technic in the solution of health problems.

If health examinations are conducted as they should be and if opportunity is given for follow-up consultations and even a certain amount of treatment, a wonderful opportunity is afforded for informal health instruction of the highest type. It is too often the case that the busy practitioner has neither time nor inclination to instruct his patients. There are probably few times when the patient sees his doctor that he does not feel the urge to ask questions and learn more about the basic facts of his case but he is sometimes kept silent by the doctor's attitude toward questions. Individual contacts made with students in the college health office should be regarded as opportunities for worth-while instruction. The time when a student is face to face with a health problem that brings him to the office for consultation is the ideal time for giving instruction along all lines pertaining to his case. He may even be directed to literature on the subject.

Health from Textbooks

Although the modern trend is to emphasize the informal side of health instruction, no programme of health guidance is complete without a certain amount of formal classroom instruction. The biggest problem in this connection is what not to teach. The temptation is great to include in the subject-matter much that is really intended only for the specialist. The amount of available material is almost limitless, but instructors must realize that the average college student is seeking only those things which he himself can use in making his life more complete.

Health educators must make a distinction between the medical student and the student whose major interest is in something else. If too much involved detail is presented, the student "cannot see the woods for the trees" and he becomes disinclined toward further investigation.

Only those subjects should be presented whose application to the everyday life of the student is fairly obvious. Among these are a study of the fundamentals of body structure and body functions, personal hygiene, mental hygiene, social hygiene, first aid, those phases of home nursing and care of the sick which every one should know, and—in teachers' colleges—the hygiene of the schoolroom. The subjects named are usually taught in the health department proper. Other departments have a close relationship to health. Bacteriology, physiological chemistry, clothing, dietetics and sociology all aid in rounding out the programme of formal health instruction. This is not a complete list.

Health Practice

Health practice is considered as synonymous with physical activities or physical education. In reality it should include all preventive and therapeutic health measures advocated by the health departmant whether or not such measures have to do with physical activities. In the college programme the student should be urged to develop into a healthier and more complete physical being just as he is urged to develop mentally. This may include attention to decayed teeth, softened gums, imperfect vision, weight and postural defects.

That part of the health practice programme which is included in physical activities undergone radical changes in the last thirty years. Then military precision and unison were emphasized. To day the programme of physical activities makes a stronger appeal to the play instinct, which is present even in adults and needs opportunity for expression. To-day the subject-matter and the manner of presentation are planned so that there is an appeal to the sense of enjoyment. This increases the likelihood that the student will take at least a part of the physical activities programme out into life with him. A veriety of activities must be presented in order that each student may find something he can use in latter life.

In fact, the carry-over into life after college should be emphasized all through any programme of health guidance. Before he has left college the student should have learned to regard regular medical and dental inspections with their subsequent preventive measures as necessary and sensible steps in health economy just as a regular inspection of his automobile is an economic measure. The value of a wholesome diet should be indelibly stamped on his mind. He should have acquired a liking for worth-while literature on health.

College graduates should be leaders wherever they are. The example that the college sets in health guidance should make the graduate unselfish in this respect. He should be a leader in the movement for better health in his community. The teamwork necessary in games and other physical activities and the effect that individual preventive health measures have on the health of the entire student body aid in the development of a social conciousness necessary in the mental make-up of any community leader.

(*Courtesy of Hygeia—A. M. A.*)